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What is and What Should Never Be Privileged in North Carolina: The Peer Review Privilege After Armstrong v. Barnes

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"What Is and What Should Never Be"[1] Privileged in North Carolina: The Peer Review Privilege After *Armstrong v. Barnes*[*]

In 1988, Dr. James Barnes, Jr. began abusing drugs as a second-year obstetrics resident facing heightened stress levels and ready access to controlled substances.[2] He then entered and completed treatment in the North Carolina Physicians Health Program ("PHP"),[3] a program designed to treat impaired physicians.[4] After relapsing two years later and losing his job with a group practice, Dr. Barnes again sought treatment through the PHP and voluntarily surrendered his medical license to the North Carolina Medical Board ("Board").[5] He received a temporary medical license, which required periodic re-issuance, contingent on compliance with mandatory drug abuse monitoring through the PHP.[6] Then, in order to regain his hospital privileges at Catawba Memorial Hospital, Dr. Barnes was required to appear in order to testify before the Catawba Memorial credentialing committee, which granted his privileges, conditioned again on his continued participation in the PHP drug abuse monitoring.[7] After being monitored and remaining drug-free for some time, Dr. Barnes relapsed and began abusing drugs once again.[8]

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1. LED ZEPPELIN, *What Is and What Should Never Be*, *on* LED ZEPPELIN II (Atlantic Records 1969).

2. Armstrong v. Barnes, 171 N.C. App. 287, 289, 614 S.E.2d 371, 373, *discretionary review denied*, 360 N.C. 60, 621 S.E.2d 173 (2005).

3. While the opinion states that Dr. Barnes "sought help and treatment" through the PHP, *id.*, it is unclear whether he voluntarily entered the program or whether his participation was required after his drug abuse was discovered. *See infra* note 111 and accompanying text (discussing the number of impaired physicians who enter the PHP voluntarily relative to those who are referred by third parties).

4. *Armstrong*, 171 N.C. App. at 289, 614 S.E.2d at 373. These impaired physicians programs are the programs contemplated by section 90-21.22(a) of the General Statutes of North Carolina. *See id.* at 291, 614 S.E.2d at 374; *infra* notes 29–34 and accompanying text. In North Carolina, this program is called the North Carolina Physicians Health Program. *See generally* North Carolina Physicians Health Program [hereinafter NCPHP], http://www.ncphp.org (last visited Aug. 2, 2007); *infra* note 34.

5. *Armstrong*, 171 N.C. App. at 289, 614 S.E.2d at 373.

6. *Id.*

7. *Id.*

8. *Id.* The actual relapse date is a point of contention in this case. During a deposition, Dr. Barnes admitted that he had started abusing drugs again in April 2000. *Id.* However, the plaintiffs pointed to evidence suggesting that he was under the influence in February, which is the relevant time period. *See* Brief of Plaintiffs-Appellees at 11–13,

Before the drug monitoring discovered his drug use in May 2000, his performance again suffered and he allegedly injured Emily Armstrong while delivering her by cesarean section.[9] The child and her parents filed suit, alleging two separate causes of action: that Emily's brain injury resulted from the medical malpractice and negligence of Dr. Barnes and from the hospital's negligent oversight and credentialing of Dr. Barnes.[10]

The plaintiffs' claims relied on evidence of Dr. Barnes's history of drug abuse, coupled with circumstantial information indicating that he was under the influence at the time of the birth.[11] Because both the PHP and the credentialing committee acted, in part, to monitor Dr. Barnes and to ensure that he was not abusing drugs, the information and records these two entities created and considered were valuable sources from which the plaintiffs could obtain such evidence. The "medical review committee privilege," created by section 131E-95(b) of the General Statutes of North Carolina, governs the discoverability of the information created and considered by "medical review committees," such as the Catawba Memorial credentialing committee.[12] While this privilege keeps most of this information confidential, "information, documents, or records *otherwise available*" are not barred from discovery "merely because they were presented during proceedings of the committee."[13] Thus,

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Armstrong, 171 N.C. App. 287, 614 S.E.2d 371 (No. COA04-300) (arguing that several simple mistakes Dr. Barnes made during, and prior to, delivery suggest he was under the influence at the time of the mistakes).

9. *Armstrong*, 171 N.C. App. at 288–89, 614 S.E.2d at 373–74. As a result of the brain injury suffered at birth, Emily Armstrong developed cerebral palsy. Brief of Plaintiffs-Appellees, *supra* note 7, at 2. She is now unable to "sit, crawl, walk, or talk," and she requires "skilled nursing care" for up to twenty hours every day. *Id.*

10. *Armstrong*, 171 N.C. App. at 288–89, 614 S.E.2d at 373.

11. *See* Brief of Plaintiffs-Appellees, *supra* note 7, at 2–3, 10–13.

12. *See* N.C. GEN. STAT. § 131E-95(b) (2005). These committees evaluate the "quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing," *id.* § 131E-76(5), and should not be confused with peer review activities, such as the PHP. *See infra* note 15 (distinguishing peer review activities from medical review committee activities).

13. § 131E-95(b) (emphasis added). This will be referred to as the "otherwise available" proviso throughout this Recent Development. Additionally,

> [d]ocuments otherwise available as public records . . . do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings.

Id.

the plaintiffs would have access to such information notwithstanding the medical review committee privilege.[14]

On the other hand, the "peer review privilege" bars from discovery "nonpublic information acquired, created, or used in good faith"[15] by peer review activities, such as the PHP.[16] Prior to *Armstrong v. Barnes*,[17] the North Carolina Court of Appeals had concluded that this privilege protected all documents related to a physician's participation in the PHP.[18] Thus, Dr. Barnes's participation in the PHP would most likely have foreclosed any meaningful discovery of this information. Recognizing this possibility as unjust, the *Armstrong* court limited the scope of the peer review privilege, holding that it did not "shield the details of [Dr. Barnes's] drug abuse from discovery to the extent his knowledge of those details exists irrespective of his participation in the PHP."[19]

This Recent Development contends that the peer review privilege should be limited in a manner similar to the medical review committee privilege and that the *Armstrong* court was correct in taking a step in this direction. This Recent Development will begin with an overview of these two privileges. Then, it will analyze the *Armstrong* decision in light of prior case law dealing with these two privileges. Next, a discussion of the public interests furthered by these two privileges will support a conclusion that the interest associated with the medical review committee privilege is of greater social importance than the interest advanced by the peer review

14. *See infra* note 28 (discussing further why this would not bar discovery).

15. N.C. GEN. STAT. § 90-21.22(e) (2005).

16. Unlike medical review committees, peer review activities such as the PHP are governed by section 90-21.22. Such activities include "investigation, review, and evaluation of records, reports, complaints, litigation and other information" about the practices of physicians, including programs for impaired physicians. § 90-21.22(a); *see infra* notes 29–34 and accompanying text (discussing these programs more thoroughly). Thus, for purposes of this Recent Development, "peer review" will refer to the process by which the Board and/or physicians monitor the practices and practice patterns of other physicians in order to ascertain their ability to safely and effectively practice medicine. This should be distinguished from "peer review" in the research context, for example, in which it refers to the process by which research is reviewed by others in order to confirm its accuracy and reliability.

17. 171 N.C. App. 287, 614 S.E.2d 371, *discretionary review denied*, 360 N.C. 60, 621 S.E.2d 173 (2005).

18. Sharpe v. Worland, 137 N.C. App. 82, 90, 527 S.E.2d 75, 80 (2000). The court found it immaterial that some of the information sought by the plaintiffs had been obtained through either the hospital's credentialing procedures or a third party's participation in the PHP's treatment of the defendant-physician. *Id.* at 89, 527 S.E.2d at 79–80.

19. *Armstrong*, 171 N.C. App. at 292, 614 S.E.2d at 375.

privilege. Finally, this Recent Development will argue that the purpose underlying the peer review privilege does not justify a complete bar on plaintiffs' discovery of information pertaining to a physician's drug use.

The two privileges—the peer review privilege and the medical review committee privilege—with which the court of appeals was most concerned in *Armstrong*[20] are governed by sections 90-21.22(e)[21] and 131E-95(b)[22] of the General Statutes of North Carolina, respectively. While both privileges relate to physician review activities, they govern different types of review committees and, therefore, involve somewhat different interests.

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20. Dr. Barnes actually asserted privileges under sections 90-21.22(e), 131E-95(b), 90-21.22A(c), and 131E-97.2 of the General Statutes of North Carolina. *Id.* at 291–92, 614 S.E.2d at 375. However, the court only addressed the first two, finding that section 90-21.22A(c) was "functionally identical" to section 131E-95(b), *id.* at 294–95, 614 S.E.2d at 376–77, and that section 131E-97.2 was inapplicable, *id.* at 295, 614 S.E.2d at 377.

21. The peer review privilege statute provides:

> Any confidential patient information and other nonpublic information acquired, created, or used in good faith . . . pursuant to this section shall remain confidential and shall not be subject to discovery or subpoena in a civil case. No person participating in good faith in the peer review or impaired physician or impaired physician assistant programs of this section shall be required in a civil case to disclose any information acquired or opinions, recommendations, or evaluations acquired or developed solely in the course of participating in any agreements pursuant to this section.

§ 90-21.22(e).

22. The medical review committee privilege statute provides:

> The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records . . . and shall not be subject to discovery or introduction into evidence in any civil action against a hospital, an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. Documents otherwise available as public records . . . do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings.

Id. § 131E-95(b).

Under the Hospital Licensure Act,[23] "medical review committees"[24] are defined as certain "committees formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, *including medical staff credentialing*."[25] Thus, the Catawba Memorial credentialing committee, before which Dr. Barnes testified, is included in this definition. Section 131E-95(b) of the General Statutes of North Carolina creates the "medical review committee privilege," which governs the discoverability of the information that these committees create and consider.[26] As a general rule, this privilege keeps confidential and bars from discovery three categories of evidence: the proceedings of a medical review committee, the records and materials it produces, and the materials it considers.[27] As an exception under this last category, however, "information, documents, or records *otherwise available*" are not barred from discovery "merely because they were presented during proceedings of the committee."[28] By virtue of this "otherwise available" proviso, "information not generated by the committee itself but merely presented to it . . . may be discovered and used in evidence even though [it was] considered by the medical review committee."[29]

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23. N.C. GEN. STAT. §§ 131E-75 to -99 (2005). The Act's purpose is to "promote public health, safety and welfare," and to establish and enforce "basic standards for the care and treatment of patients in hospitals." § 131E-75(b); *see infra* notes 64–76 and accompanying text (discussing the privileges' purposes).

24. Other states and some commentators use other names for these types of committees. Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 180 (1988); *see* ARK. CODE ANN. § 20-9-501 (2005) ("peer review committee[s]"); GA. CODE ANN. § 31-7-130 (2006) ("peer review groups"); *see also* Katherine T. Stukes, Recent Development, *The Medical Review Privilege After* Virmani, 80 N.C. L. REV. 1860, 1861 (2002) (referring to the privilege afforded under section 131E-95 as "North Carolina's Medical Peer Review Privilege"). Regardless of the name given, the statutes are generally similar in purpose, aiming to protect medical review evaluation by hospitals. Creech, *supra*, at 179–80. These committees, and the privileges covering them, should not be confused with peer review activities, such as the PHP. *See supra* notes 11, 15 and accompanying text (discussing the distinction).

25. § 131E-76(5) (emphasis added). The statute lists four specific types of committees that qualify: committees of (1) a state or local professional society; (2) a medical staff of a hospital; (3) a hospital or hospital system, if certain requirements are met; and (4) a peer review corporation or organization. *Id.*

26. *See id.* § 131E-95(b).

27. *Id.*; *see supra* note 21 (quoting the statute).

28. § 131E-95(b) (emphasis added).

29. Shelton v. Morehead Mem'l Hosp., 318 N.C. 76, 83–84, 347 S.E.2d 824, 829 (1986). Thus, because Dr. Barnes created and knows the details of his drug abuse apart from the privileged committee records, those details do not become immune from discovery merely

On the other hand, section 90-21.22 of the General Statutes of North Carolina governs "peer review activities," including programs such as the PHP.[30] This statute authorizes the North Carolina Medical Board to enter into agreements with the North Carolina Medical Society ("Medical Society") "for the purpose of conducting peer review activities."[31] Such activities include "investigation, review, and evaluation of records, reports, complaints, litigation and other information about the practices and practice patterns of physicians" and "shall include programs for impaired physicians."[32] The PHP, which grew out of an agreement between the Board and the Medical Society[33] and was "created to aid impaired physicians,"[34] is therefore the type of organization contemplated by section 90-21.22(a).[35]

The "peer review privilege," created by section 90-21.22(e), bars from discovery and keeps confidential "nonpublic information acquired, created, or used in good faith" by programs such as the PHP.[36] Further, no person participating in good faith in these programs "shall be required in a civil case to disclose any information acquired or opinions, recommendations, or evaluations acquired or developed *solely* in the course of participating in any agreements pursuant to this section."[37] While section 90-21.22(e) does not include

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because they were conveyed to the committee. Armstrong v. Barnes, 171 N.C. App. 287, 294, 614 S.E.2d 371, 376, *discretionary review denied*, 360 N.C. 60, 621 S.E.2d 173 (2005).

30. N.C. GEN. STAT. § 90-21.22 (2005); *see infra* note 34 (discussing the creation of the PHP and why it constitutes a peer review activity).

31. § 90-21.22(a).

32. *Id.*

33. In 1988, an agreement between the Board and the Medical Society created the North Carolina Physicians Health and Effectiveness Program, which was renamed the North Carolina Physicians Health Program. North Carolina Physicians Health Program: Public Protection and Professional Rehabilitation [hereinafter Protection and Rehabilitation], http://www.ncmedboard.org (follow "For Physicians" hyperlink; then follow "History and Purpose" hyperlink under "North Carolina Physicians Health Program") (last visited Aug. 2, 2007).

34. *Armstrong*, 171 N.C. App. at 289, 614 S.E.2d at 373.

35. *See, e.g.*, Sharpe v. Worland, 137 N.C. App. 82, 87, 527 S.E.2d 75, 78 (2000) (stating that the creation of the PHP immediately followed the enactment of section 90-21.22); NCPHP Program Overview, http://www.ncphp.org/code/progrov.htm (last visited Aug. 2, 2007) ("[The PHP] was established by *North Carolina State Statute 90-21.22.*"). For a general discussion of the background of the PHP, see Amicus Curiae Brief of North Carolina Physicians Health Program, Inc. at 3–7, *Armstrong*, 171 N.C. App. 287, 614 S.E.2d 371 (No. COA04-300) [hereinafter Amicus Curiae Brief of NCPHP] (stating that the enactment in 1987 of section 90-21.22, after considerable joint efforts by the Medical Society and the Board, led directly to the creation of the PHP in 1988); Protection and Rehabilitation, *supra* note 32.

36. § 90-21.22(e); *see supra* note 20 (quoting the statute).

37. § 90-21.22(e) (emphasis added).

an "otherwise available" proviso, the inclusion of the word "solely" in the second sentence of the statute may impose an exception to the general rule of nondisclosure—similar to the exception created by the otherwise available" proviso.[38] In other words, unlike the PHP or the Medical Society itself, a physician who knew the details of his drug abuse prior to participating in the PHP would not have acquired that information "solely in the course of" his participation. As a result, the peer review privilege may not attach, and he may be required to disclose this information in a civil case.

The North Carolina Court of Appeals recently addressed both the peer review and medical review committee privileges in *Armstrong*.[39] When Dr. Barnes refused to answer deposition questions about his drug history, the Catawba County Superior Court entered the following protective order:

> Dr. Barnes does not have to give deposition testimony about the testimony he gave to the [Catawba Memorial] medical review committee or about the evidence he presented at the medical review committee hearing. Dr. Barnes does have to answer deposition questions even if the same questions were asked at the medical review committee [hearing].[40]

Dr. Barnes appealed, asserting that this order failed to address the peer review privilege and that it improperly required him to disclose privileged materials under both the peer review and medical committee privileges.[41]

After initially holding that it was error not to address the peer review privilege, the court of appeals in *Armstrong* determined that this privilege did not extend to all details of Dr. Barnes's drug abuse.[42] Although the court acknowledged the legislative intent to create a broad privilege through section 90-21.22, it did not find any intent "to insulate a participant from disclosing the details of his drug abuse merely because he related [those] details" while participating in the PHP.[43] The court reasoned that to so hold would allow a participant

38. This will be referred to as the "solely" proviso.

39. For a discussion of the facts in this case, see *supra* notes 1–10 and accompanying text.

40. *Armstrong*, 171 N.C. App. at 290, 614 S.E.2d at 374 (alterations in original) (quoting Order, Armstrong v. Barnes, No. 03-CVS-525 (Catawba County Super. Ct. Oct 10, 2003)).

41. *Id.* at 291–92, 614 S.E.2d at 374–75. Dr. Barnes also invoked two additional statutes in his appeal. *See supra* note 19.

42. *Armstrong*, 171 N.C. App. at 291–92, 614 S.E.2d at 375.

43. *Id.*

"to use the program as a shield to escape liability for his negligence by foreclosing any meaningful discovery by an injured party."[44] The court of appeals concluded that the peer review privilege does not extend to records or information unrelated to a physician's PHP participation, holding that "Dr. Barnes may not invoke the privilege . . . to shield the details of his drug abuse from discovery to the extent his knowledge of those details exists irrespective of his participation in the PHP."[45]

This construction of the peer review privilege represents a departure from precedent established four years earlier in *Sharpe v. Worland*.[46] Unlike the plaintiffs in *Armstrong*, who sought deposition testimony from Dr. Barnes himself, the plaintiffs in *Sharpe* sought testimony from, and documents in the possession of, the hospital.[47] Therefore, the *Sharpe* court addressed whether and to what extent documents in the possession of a hospital, pertaining to a physician's PHP participation, were privileged.[48] Based primarily on its assertion that "allowing discovery of documents considered by the PHP, and which are otherwise available, would undoubtedly discourage physicians from seeking treatment for their impairments,"[49] the court held that all such documents were protected from discovery under the peer review privilege.[50] Thus, after *Sharpe*, even documents "that may have come into [a hospital's] possession through third party participation in the PHP's treatment of [a physician]"[51] and those that "are available from a source other than the PHP"[52] were considered privileged.

Just how much of a departure the *Armstrong* holding represents, however, is not immediately clear. After all, the *Sharpe* court addressed the scope of the peer review privilege with respect to

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44. *Id.* at 292, 614 S.E.2d at 375.

45. *Id.*

46. 137 N.C. App. 82, 527 S.E.2d 75 (2000).

47. In *Sharpe*, the plaintiffs alleged medical malpractice against the defendant-physician and negligent retention against the defendant-hospital. *Id.* at 83–84, 527 S.E.2d at 76. When the plaintiffs noticed the deposition of the hospital and requested certain documents, including those containing information about the physician's PHP participation, the defendant-hospital moved for a protective order, invoking section 90-21.22(e). *Id.* at 84, 527 S.E.2d at 77.

48. *Id.* *Compare id. with Armstrong*, 171 N.C. App. at 291, 614 S.E.2d at 375 (addressing whether the peer review privilege extends to all details of a PHP participant's drug abuse).

49. *Sharpe*, 137 N.C. App. at 87, 527 S.E.2d at 79.

50. *Id.* at 90, 527 S.E.2d at 80.

51. *Id.* at 89, 527 S.E.2d at 80.

52. *Id.* at 85, 527 S.E.2d at 77.

documents in the possession of a hospital that related to a physician's PHP participation, while *Armstrong* addressed the scope of the privilege where the source of the information sought was the physician himself. As such, the peer review privilege's "solely" proviso may reconcile the two holdings.[53] However, the tone of the two decisions could not be further apart. The *Sharpe* court contrasted the purpose and language of the peer review privilege with that of the medical review committee privilege, and found "clear evidence that the Legislature intended to grant a broader privilege" with respect to peer review that encompassed documents available from a source other than the PHP.[54] In contrast, the *Armstrong* court found no "intent to insulate a participant from disclosing the details of his drug abuse merely because he related [those] details" to the PHP,[55] suggesting that it applied the "solely" proviso to limit the previously broad privilege in a manner consistent with the "otherwise available" proviso.

After determining the scope of the peer review privilege, the *Armstrong* court then addressed whether, in light of the medical review committee privilege, Dr. Barnes should be required to answer deposition questions even if the same questions were asked at the credentialing committee hearing.[56] Relying on *Shelton v. Morehead Memorial Hospital*[57] and *Whisenhunt v. Zammit*,[58] the *Armstrong* court first noted that section 131E-95(b) provides "a broad privilege that protects 'a medical review committee's (1) proceedings; (2) records and materials it produces; and (3) materials it considers' "[59] and that the "otherwise available" proviso establishes "a balance between this broad privilege and the interest of allowing reasonable discovery."[60] The court then distinguished both *Shelton* and

53. *See supra* note 37 and accompanying text (discussing the "solely" proviso).

54. *Sharpe*, 137 N.C. App. at 87–88, 527 S.E.2d at 78–79. The *Sharpe* plaintiffs invoked *Shelton v. Morehead Memorial Hospital*, 318 N.C. 76, 347 S.E.2d 824 (1986), asserting that the documents were discoverable because they were available from a source other than the PHP, *Sharpe*, 137 N.C. App. at 85, 527 S.E.2d at 77. Because *Shelton* addressed section 131E-95, the *Sharpe* court distinguished the two statutes on the grounds of the "otherwise available" proviso and concluded that, unlike the medical review committee privilege, the peer review privilege protected documents even if they were available from a source other than the PHP. *Id.* at 85–88, 527 S.E.2d at 77–79.

55. Armstrong v. Barnes, 171 N.C. App. 287, 292, 614 S.E.2d 371, 375, *discretionary review denied*, 360 N.C. 60, 621 S.E.2d 173 (2005).

56. *Id.*

57. 318 N.C. 76, 347 S.E.2d 824 (1986).

58. 86 N.C. App. 425, 358 S.E.2d 114 (1987).

59. *Armstrong*, 171 N.C. App. at 293, 614 S.E.2d at 376 (quoting *Shelton*, 318 N.C. at 83, 347 S.E.2d at 829).

60. *Id.*

Whisenhunt—which had held that the requested documents were protected under section 131E-95(b)—on the same grounds: while the plaintiffs in these prior decisions had sought discovery from the hospital of certain medical review committee records,[61] the *Armstrong* plaintiffs sought disclosure of Dr. Barnes's drug abuse directly from Dr. Barnes.[62] Thus, "[u]nlike the hospitals in *Shelton* and *Whisenhunt*, Dr. Barnes is an original source with respect to the information sought because he created and knows the details of his drug abuse outside the privileged proceedings of the credentialing committee and the records it produced."[63] Therefore, the court concluded, "Dr. Barnes, as an original source, may not invoke [section] 131E-95(b) to shield himself from answering deposition questions regarding the details of his drug abuse merely because he disclosed those details during the credentialing committee proceedings and those details were presumably included in the committee's records."[64]

Before determining the relative wisdom of the *Armstrong* holding, it is important first to understand the purposes underlying these two privileges. The General Assembly, the court of appeals, and the PHP have all acknowledged that the purpose of the peer review privilege is to encourage impaired physicians to seek the treatment they need. The 1987 General Assembly enacted section 90-21.22 based on the North Carolina Medical Malpractice Study Commission's recommendation that licensing boards of the heath care professions be empowered to enter into agreements to conduct peer review of impaired physicians.[65] The commission based this recommendation on the fact that physicians are more prone to drug abuse and that " 'the efforts of the profession to help itself should be supported.' "[66] The General Assembly's acceptance of this

61. "In *Shelton*, the plaintiffs sought discovery from the defendant hospital's medical review committee records and information regarding the review proceedings with respect to the defendant doctor." *Id.* (citing *Shelton*, 318 N.C. at 81, 347 S.E.2d at 828). "[T]he plaintiffs in *Whisenhunt* sought discovery from a hospital of its 'credentialing records' concerning the defendant doctor." *Id.* at 293–94, 614 S.E.2d at 376 (citing *Whisenhunt*, 86 N.C. App. at 426, 358 S.E.2d at 115).

62. *Id.* at 294, 614 S.E.2d. at 376.

63. *Id.*

64. *Id.*

65. Sharpe v. Worland, 137 N.C. App. 82, 86–87, 527 S.E.2d 75, 78 (2000); *see* Amicus Curiae Brief of NCPHP, *supra* note 34, at 4.

66. *Sharpe*, 137 N.C. App. at 86–87, 527 S.E.2d at 78 (quoting N.C. MED. MALPRACTICE STUDY COMM'N, REPORT AND RECOMMENDATIONS TO THE 1987 N.C. GENERAL ASSEMBLY, at Recommendations 16 (1987)). Thus, the commission's primary argument was a plea to support the effort to help impaired physicians. While many studies

recommendation suggests that it enacted section 90-21.22 in order to facilitate the treatment of impaired physicians. Furthermore, the court of appeals has stated, "It is clear ... that the Legislature enacted [section] 90-21.22 with the intent to encourage health care providers to seek treatment for their impairments."[67] Similarly, the PHP recognized this same purpose when it identified section 90-21.22 as "an impetus to physician participation in the impairment programs of PHP."[68]

The peer review privilege does result, to some extent, in higher quality health care, because rehabilitated physicians will dispense better treatment to patients. However, as section 90-21.22 is one of more than ninety-nine statutory sections seeking to improve the practice of medicine in some fashion,[69] the goal of improved health care should not be viewed as the primary purpose of the peer review privilege. Rather, this goal seems to be secondary to the statute's primary purpose: encouraging impaired physicians to get treatment.

Turning to the purpose of the medical review committee privilege, the North Carolina Hospital Association and the North Carolina Medical Society have recognized that peer review,[70]

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have been conducted attempting to determine whether physicians abuse drugs at a higher rate than does the general population, there does not appear to be any consensus regarding the answer. Richard D. Aach et al., *Alcohol and Other Substance Abuse and Impairment among Physicians in Residency Training*, 116 ANNALS INTERNAL MED. 245, 246 (1992). *Compare id.* (citing "estimates that physicians are 30 to 100 times more likely than the general population to become addicted to narcotics") (citing Thomas G. Webster, *Problems of Drug Addiction and Alcoholism Among Physicians*, *in* THE IMPAIRED PHYSICIAN 27, 28 (Stephen C. Scheiber & Brian B. Boyle eds., 1983)) *with* Patrick H. Hughes et al., *Prevalence of Substance Abuse Among US Physicians*, 267 JAMA 2333, 2336, 2338 (1992) (finding that the physicians surveyed used alcohol and certain prescription drugs at a higher rate than did the general population, but noting that literature on the topic consistently suggests that physicians are no more susceptible to alcohol abuse).

67. *Sharpe*, 137 N.C. App. at 87, 527 S.E.2d at 78.

68. Amicus Curiae Brief of NCPHP, *supra* note 34, at 11; *see also id.* at 12 (stating that the issues facilitated by section 90-21.22 "include encouragement and incentive for getting impaired physicians into the PHP program, evaluation and analysis of particular impairment problems, assessment and recommendation of treatment alternatives, and monitoring during active PHP participation"); Protection and Rehabilitation, *supra* note 32 (stating that the purpose of the predecessor to the PHP was "to identify impaired physicians, confront them, and, where possible, encourage and assist in their rehabilitation"). *But see* NCPHP, *supra* note 3 ("Improving the quality of health care for the people in North Carolina through assurance of healthy medical professionals.").

69. *See* N.C. GEN. STAT. §§ 90-1 to -21-56 (2005) (seeking to improve the practice of medicine, each section in its own way).

70. While these organizations refer to "peer review," their definition of this term reveals that they are referring to what this Recent Development has termed medical review committee activities. *See* Amici Curiae Brief (North Carolina Hospital Association

conducted by medical review committees such as the Catawba Memorial credentialing committee, is "essential to the provision of high quality health care to patients."[71] Because the Catawba Memorial credentialing committee evaluated Dr. Barnes's competency to administer to patients and is, thus, "essential to the provision of high quality health care,"[72] this suggests that section 131E-95, which governs such committees, is similarly meant to ensure high quality health care. Additionally, as one section within the Hospital Licensure Act,[73] section 131E-95 represents a legislative attempt to bring about the purposes of that Act, which are to "promote public health, safety and welfare" and to "develop[], establish[] and enforce[] ... basic standards for the care and treatment of patients in hospitals."[74] Because section 131E-95 is meant to promote public health and higher standards of health care in hospitals, and because it governs medical review committees, which are essential to high quality health care, it becomes evident that the purpose of section 131E-95—and the medical review committee privilege—is to promote quality health care in hospitals.[75]

Arguably, this same assessment could also apply to the peer review privilege and impaired physician programs, such as the PHP, since they represent one type of peer oversight for physicians. In general, however, most of the discussion about the importance of medical peer oversight relates to statutes such as section 131E-95 (as opposed to section 90-21.22) and committees such as the Catawba Memorial credentialing committee (as opposed to programs for impaired physicians, such as the PHP).[76] Furthermore, the impaired

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and the North Carolina Medical Society) at 6, Virmani v. Presbyterian Health Servs. Corp., 350 N.C. 449, 515 S.E.2d 675 (1999) (No. 62PA97-2) [hereinafter Amici Curiae Brief of NCHA and NCMS] ("Peer review is the process by which hospitals ... evaluate the competency of a colleague safely to administer to patients.").

71. *Id.*

72. *Id.*

73. N.C. GEN. STAT. § 131E-75(a) (2005).

74. § 131E-75(b).

75. *But see* Shelton v. Morehead Mem'l Hosp., 318 N.C. 76, 82, 347 S.E.2d 824, 828 (1986) (identifying "the promotion of candor and frank exchange in peer review proceedings" as the purpose of section 131E-95). This Recent Development contends that this is more along the lines of the statute's means and that, pursuant to the legislative history and the purposes of medical review committees, generally, and the Hospital Licensure Act, in particular, the statute's true purpose is to improve the quality of available health care. *See supra* notes 69–73 and accompanying text.

76. *See, e.g.*, Cameron v. New Hanover Mem'l Hosp., 58 N.C. App. 414, 435–37, 293 S.E.2d 901, 914–15 (1982) (construing section 131-170, the predecessor to section 131E-95); Amici Curiae Brief of NCHA and NCMS, *supra* note 69, at 6, 9 (discussing the type of peer review that facilitates evaluation of a physician's competency to safely treat patients;

physician peer review programs created under section 90-21.22 are different from the medical review activities conducted under section 131E-95. If this were not the case, section 131E-95 could have governed these activities as well, rendering section 90-21.22 unnecessary. Thus, the very fact that section 90-21.22 was ever enacted lends support to the proposition that impaired physician peer review programs are substantively different from other medical review committees.[77]

In summary, the purpose of the medical review committee privilege is to promote quality health care in hospitals, while that of the peer review privilege is to encourage impaired physicians to get necessary treatment. While the latter is, without a doubt, a noble purpose that significantly benefits the public, encouraging impaired physicians to seek treatment is simply not as important to the general public as promoting higher quality health care.

Physician impairment is a significant problem that demands attention. "The ills of the human condition are at least as common to licensed health care professionals as they are to everyone else."[78] This, in combination with doctors' relatively easy access to certain drugs, makes them at least as prone to drug addiction as other groups.[79] Thus, the question becomes not whether physician

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more informed decisions regarding physician hiring, termination, and disciplinary action; and the ability of physicians to review care provided by doctors and to suggest improvements in a non-confrontational manner); *id.* at 11–12 (invoking section 131E-95 as proof that both the legislature and courts of North Carolina have recognized the importance of confidential peer review to the ongoing provision of quality health care); Stukes, *supra* note 23, at 1862 (identifying the functions of peer review as "examining the credentials of physicians applying for staff privileges" and "monitoring the quality of patient care given by physicians who already possess staff privileges"). *But see* Amici Curiae Brief of NCHA and NCMS, *supra* note 69, at 7 (noting that peer review contributes to the improvement of patient care in several ways, among which is " 'treatment of those whose abilities are impaired and in need of rehabilitation' " (quoting PEER REVIEW IMMUNITY TASK FORCE, AM. HOSP. ASS'N, IMMUNITY FOR PEER REVIEW PARTICIPATION IN HOSPITALS 9 (1989))).

77. This does not necessarily mean that the discussion about the importance of peer oversight in the medical profession, *see supra* notes 69–73 and accompanying text, would not also apply in some degree to programs such as the PHP. However, those discussions related primarily to credentialing committees and other similar peer oversight entities. Because of the differences between peer review for impaired physicians and medical review committees, *see supra* notes 11, 15 and accompanying text, a discussion about one does not necessarily apply to the other.

78. Protection and Rehabilitation, *supra* note 32.

79. Sharpe v. Worland, 137 N.C. App. 82, 86, 527 S.E.2d 75, 78 (2000) (stating that physicians are *more* prone to addiction than other similar groups). *Compare id. with supra* note 65 (discussing whether physicians are, in fact, more prone to addiction than other groups).

impairment is a problem, but rather just how significant the problem is. As the PHP provides these physicians an opportunity to seek treatment for their addictions and other impairments,[80] those physicians who need treatment for their impairments participate in the PHP. Therefore, statistics on PHP participation provide an indication of the total number of physicians who need treatment and who would, therefore, benefit from the peer review privilege—which is designed to encourage such participation.[81]

From 1988 through 2006, the PHP had treated almost nineteen hundred medical professionals.[82] There are currently more than two hundred active PHP participants,[83] and the number of those entering the program annually has increased dramatically during the twenty-first century.[84] These figures indicate that physician impairment is a significant problem, and it appears that the PHP is successful in rehabilitating those participating in the program.[85]

Similarly, as the purpose of the medical review committee privilege is to promote improved health care in North Carolina hospitals, the number of people discharged from North Carolina hospitals should be a good indication of the number of people who

80. NCPHP Program Overview, *supra* note 34.

81. It is likely that many physicians who are addicted to drugs are not participants in the PHP because, for instance, they have not been discovered. While PHP participation does not, therefore, represent an exact indication of those who would benefit from such programs, it is currently the best indicator available for purposes of this Recent Development.

82. NCPHP Statistics as of 12/31/2006, http://www.ncphp.org/code/stats.htm (last visited Aug. 2, 2007) (maintaining that 1,891 physicians, physician assistants, veterinarians, and veterinarian technicians have participated in the program). Of these participants, 1,726 were physicians. *Id.*

83. NCPHP History, http://www.ncphp.org/code/about.htm (last visited Aug. 2, 2007). While this data does not appear to be current, compare *id.* (citing 1,725 participants through 2005) with NCPHP Statistics as of 12/31/2006, *supra* note 81 (citing 1,891 participants through 2006), it is the only data available on the PHP's website with respect to current participation.

84. From 1988 to 1999, an average of 74.92 people entered the PHP program annually. NCPHP Statistics as of 12/31/2006, *supra* note 81. From 2000 to 2006, the numbers of new entrants have been 118, 116, 119, 138, 167, 167, and 168, respectively—an average of approximately 142. *Id.*

85. The North Carolina Medical Board asserts that over ninety percent of PHP participants have been rehabilitated. Protection and Rehabilitation, *supra* note 32. However, this statistic does not appear to be current. *Compare id.* (claiming a success rate of over ninety percent for "over 1,400 impaired practitioners") *with* NCPHP Statistics as of 12/31/2006, *supra* note 81 (indicating that the PHP has now treated over 1,890 medical professionals). Furthermore, the Board acknowledges that some PHP participants simply "cannot or will not be rehabilitated." Protection and Rehabilitation, *supra* note 32.

benefit from the privilege.[86] Therefore, comparing PHP participation statistics to statistics on the number of people discharged from North Carolina hospitals should convey an idea about the relative number of people who would benefit from the two privileges. While 1,891 impaired medical professionals treated by the PHP from 1988 to 2006 is not insignificant, it does not compare to the number of people treated by hospitals during that time. In 1996 alone, no fewer than 757,033 North Carolina residents were discharged from North Carolina hospitals.[87] By comparison, in 1996, only eighty-two medical professionals entered the PHP.[88] These numbers suggest that there are many more people in the State of North Carolina who would benefit from improved health care in hospitals—what the medical review committee privilege is intended to accomplish—than there are impaired physicians who would benefit from the peer review privilege, the purpose of which is to encourage them to seek treatment.[89] Therefore, the medical review committee privilege has more social benefit than does the peer review privilege—even conceding that the latter does result, to some degree, in better health care for the public at large.[90]

While the two statutes were enacted in order to achieve different purposes,[91] they both aim to achieve their respective goals through the same means: confidentiality and protection from discovery of certain information. All medical review committees—credentialing committees and the PHP—are effective only when those participating on both sides are honest, candid, and objective.[92] The problem, however, is that "physicians are frequently reluctant to participate in

86. Similar to PHP participation, the number of patients discharged from hospitals is not an exact representation, as many people who need hospital services never go to a hospital—often those who cannot afford it. However, it, too, serves as the best available indicator for purposes of this Recent Development.

87. KATHRYN B. SURLES & KATHLEEN JONES-VESSEY, NORTH CAROLINA HOSPITAL DISCHARGES: 1996 SUMMARY 2–3 (State Ctr. for Health Statistics, Study No. 109, 1998), *available at* http://www.schs.state.nc.us/SCHS/pdf/schs109.pdf.

88. NCPHP Statistics as of 12/31/2006, *supra* note 81.

89. The benefits of these two privileges are certainly not mutually exclusive. For example, a future hospital patient of a currently impaired physician may receive better care if that physician enters and completes treatment in the PHP prior to administering medical care. This group of hospital patients who benefit by operation of the peer review privilege, however, is a subset of the larger group that receives a benefit from the medical review committee privilege. Because there are no statistics available indicating how many patients an impaired physician is likely to treat in his lifetime after being rehabilitated, this group of overlapping beneficiaries is difficult to quantify.

90. *See supra* note 68 and accompanying text.

91. *See supra* notes 64–76 and accompanying text.

92. *See* Amici Curiae Brief of NCHA and NCMS, *supra* note 69, at 9.

peer review evaluations for fear of exposure to liability, entanglement in malpractice litigation, loss of referrals from other doctors, and a variety of other reasons."[93] The confidentiality provisions of sections 131E-95(b)[94] and 90-21.22(e)[95] combat this reluctance in that participating physicians "can be assured that their contributions will be held strictly confidential, thereby negating the possibility of individual retaliation either through litigation, or otherwise."[96]

In addition to ensuring confidentiality, section 131E-95 also "protects from discovery and introduction into evidence medical review committee proceedings and related materials because of the fear 'that external access to peer investigations conducted by staff committees stifles candor and inhibits objectivity.' "[97] Similarly, the North Carolina Court of Appeals recognized that allowing discovery of documents considered by the PHP would discourage impaired physicians from getting treatment, thus frustrating the purpose of section 90-21.22.[98]

Therefore, it has been broadly accepted that both privileges seek to foster environments in which their respective purposes can be accomplished through the same means: confidentiality and protection from discovery of certain records and information related to the committees they govern. However, the means of the medical review committee privilege have been limited by the "otherwise available" proviso of section 131E-95(b), which serves as a compromise by subordinating the goal of medical staff candor in

93. Creech, *supra* note 23, at 179. One fear is that participation might create a "reservoir" of discoverable information that a potential plaintiff might not otherwise have. Amicus Curiae Brief of NCPHP, *supra* note 34, at 8. Plaintiffs could use this information against an impaired physician to support allegations that the physician rendered treatment while impaired, or against a hospital to support allegations that it should have revoked or denied privileges.

94. *See* Amici Curiae Brief of NCHA and NCMS, *supra* note 69, at 11–14.

95. *See* Amicus Curiae Brief of NCPHP, *supra* note 34, at 11–13 (arguing that the goals of section 90-21.22 would be "infinitely more difficult to achieve, if not impossible, if medical malpractice plaintiffs [were] given access to information concerning impaired physicians' participation in PHP").

96. Amici Curiae Brief of NCHA and NCMS, *supra* note 69, at 10 (arguing about the protections under section 131E-95); *see also* NCPHP Program Overview, *supra* note 34 (stating that confidentiality and anonymity are key elements, that the names of those reported to the PHP are guarded, and that referrals can be made without fear of repercussion due to the anonymity of the sources of referrals). Confidentiality can also benefit the physician being evaluated if allegations against her prove to be groundless. *See* Amici Curiae Brief of NCHA and NCMS, *supra* note 69, at 11.

97. Shelton v. Morehead Mem'l Hosp., 318 N.C. 76, 82, 347 S.E.2d 824, 828 (1986) (quoting Cameron v. New Hanover Mem'l Hosp., 58 N.C. App. 414, 436, 293 S.E.2d 901, 914 (1982)).

98. Sharpe v. Worland, 137 N.C. App. 82, 87, 527 S.E.2d 75, 79 (2000).

some situations to allow plaintiffs access to certain evidence that would otherwise be protected.[99] Thus, the confidentiality and immunity afforded by section 131E-95(b) are not absolute; these means have been limited in certain circumstances even though they are essential to the privilege's purpose.

The success of both privileges depends on the amount of information protected from discovery: as more information is protected, it becomes more likely that the privilege's purpose will be realized.[100] As such, one would expect the amount of allowable discovery to correlate with the social utility of the respective privileges—lesser social utility should result in lesser protection from discovery. Previous interpretations by North Carolina courts got it wrong, however, by affording greater protection under the privilege that yields less social benefit.[101]

The *Armstrong* court's treatment of the peer review privilege represents a good first step toward correcting this mistake and properly limiting the privilege. Addressing the scope of the peer review privilege, the court of appeals appeared to place a limit on the privilege similar to the "otherwise available" proviso of section 131E-95(b).[102] As a result, a physician who participated in the PHP "may not invoke the privilege ... to shield the details of his drug abuse from discovery to the extent his knowledge of those details exists irrespective of his participation in the PHP."[103] In light of the plain

99. *See Shelton*, 318 N.C. at 82, 347 S.E.2d at 828 (" '[The Act] ... embraces the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence.' " (quoting *Cameron*, 58 N.C. App. at 436, 293 S.E.2d at 914)).

100. *See supra* notes 64–98 and accompanying text (discussing the implementation and purposes of the privileges as well as their relative utility).

101. *Compare Sharpe*, 137 N.C. App. at 86–90, 527 S.E.2d at 78–80 (construing section 90-21.22 broadly and affording virtually absolute protection to any documents relating to a physician's PHP participation) *with Shelton*, 318 N.C. at 83–84, 347 S.E.2d at 829 (holding that, pursuant to section 131E-95, materials not generated by the committee itself, but merely presented to it, may be discovered and used in evidence even though they were considered by the medical review committee).

102. *See supra* notes 41–44, 52–54 and accompanying text (discussing the *Armstrong* decision).

103. Armstrong v. Barnes, 171 N.C. App. 287, 292, 614 S.E.2d 371, 375, *discretionary review denied*, 360 N.C. 60, 621 S.E.2d 173 (2005). It also appears that such a physician will be required to produce documents related to his drug abuse, but unrelated to his PHP participation. In *Armstrong*, for example, the plaintiffs obtained evidence about Dr. Barnes from the following records, both of which were unrelated to his PHP participation:

> (1) the 31 August 1994 Board of Medical Examiners Order regarding Dr. Barnes, which stated Dr. Barnes had a history of drug abuse, had relapsed, and agreed to surrender his medical license for the issuance of a temporary license and (2)

language of the peer review privilege, this appears to be the only correct result. Section 90-21.22(e) states that no one participating in the PHP in good faith shall be required to disclose "any information acquired or opinions, recommendations, or evaluations acquired or developed *solely in the course of participating*" in the program.[104] A physician who knows about the details of his drug abuse "irrespective of his participation in the PHP" simply has not acquired that information "solely in the course of participating" in the PHP. As such, the statutory language is not triggered and the privilege may not act to bar discovery of this kind of information.

Similarly, the *Armstrong* court reached the only viable conclusion regarding the scope of the medical review committee privilege. In light of the "otherwise available" proviso,[105] information, documents, and records available from any source other than the "proceedings of a medical review committee, the records and materials it produces and the materials it considers" are not barred from discovery "merely because they were presented during proceedings of the committee."[106] Therefore, once the court identified Dr. Barnes as an original source with respect to the details of his drug abuse, its holding was a foregone conclusion: he may not invoke the medical review committee privilege "to shield himself from answering deposition questions regarding the details of his drug abuse merely because he disclosed those details during the credentialing committee proceedings and those details were presumably included in the committee's records."[107]

Furthermore, the *Armstrong* holding also makes sense in light of the purposes and relative utility of the two privileges at issue. Because the medical review committee privilege seeks to improve the health care provided in North Carolina hospitals,[108] it potentially benefits everyone who is admitted to a hospital for treatment. Even so, the North Carolina courts have limited the privilege to allow plaintiffs access to certain information that would otherwise be

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newspaper articles regarding Dr. Barnes's disciplinary history and surrender of his license.

Id. at 296, 614 S.E.2d at 377–78.

104. N.C. GEN. STAT. § 90-21.22(e) (2005) (emphasis added); *see supra* note 20 (quoting the statute).

105. *See supra* notes 12–13, 26–28 and accompanying text (discussing the "otherwise available" proviso).

106. N.C. GEN. STAT. § 131E-95(b) (2005); *see supra* note 21 (quoting the statute).

107. *Armstrong*, 171 N.C. App. at 294, 614 S.E.2d at 376.

108. *See supra* notes 69–74 and accompanying text.

protected.[109] On the other hand, the peer review privilege was designed to encourage impaired physicians to seek treatment.[110] While this is certainly an important purpose, it is not as socially beneficial as the goal of improving the quality of health care available in North Carolina hospitals.[111] Additionally, statistics regarding participation in the PHP raise questions as to how successful the privilege actually is in so encouraging physicians.[112] Therefore, if the goal of improved health care can be subordinated in certain circumstances in order to allow plaintiffs meaningful discovery, there is no convincing reason that the goal of encouraging physicians to seek treatment should not be similarly limited.

So, "what is and what should never be"[113] privileged in North Carolina? At this time, in light of *Armstrong v. Barnes*[114] and *Sharpe v. Worland*,[115] what *is* privileged is somewhat in question[116]—though it is clear that less information pertaining to PHP participation is privileged now than was the case prior to *Armstrong*. Regardless of prior decisions, however, the question of what *should never be* privileged is a matter of common sense: there is simply no legitimate reason that a physician such as Dr. Barnes should be allowed to shield all details of his drug abuse from discovery merely because he participated in a program designed to treat such impairments. Affording this protection would encourage physicians to participate in these programs in bad faith whenever confronted with the possibility of a lawsuit in order to foreclose potential plaintiffs from

109. *See supra* note 98 and accompanying text.

110. *See supra* notes 64–68 and accompanying text.

111. *See supra* notes 85–89 and accompanying text.

112. From 1988 to 2006, only 223 of the 1,891 total PHP participants, or just over eleven percent, entered the program of their own volition. NCPHP Statistics as of 12/31/2006, *supra* note 81. That almost ninety percent of PHP participants were referred by third parties suggests that the majority of impaired physicians have not in fact been encouraged to seek treatment for their impairments. Rather, their impairments are being discovered, and they are being forced to enter the PHP.

113. LED ZEPPELIN, *What Is And What Should Never Be*, *on* LED ZEPPELIN II (Atlantic Records 1969).

114. 171 N.C. App. 287, 614 S.E.2d 371, *discretionary review denied*, 360 N.C. 60, 621 S.E.2d 173 (2005).

115. 137 N.C. App. 82, 527 S.E.2d 75 (2000).

116. For this reason, it would be helpful if the General Assembly and/or the Supreme Court of North Carolina would provide further guidance. The General Assembly could attach comments to section 90-21.22, expounding the legislative intent underlying the statute. Alternatively, it could alter the statutory language to clarify the intended scope of its protection by either inserting an "otherwise available" proviso or explicitly stating that information "otherwise available" is privileged. The Supreme Court could also help clarify this area of the law by granting a petition for discretionary review the next time such a petition is filed with respect to an issue related to the peer review privilege.

any meaningful discovery. Because of the possibility that this might deprive injured persons of their day in court, this type of information should never be privileged in North Carolina.

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